Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0224	A. BUILDING: _____ B. WING _____	R 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARTREE HOUSE	8004 SHADOW OAK LANE PASADENA, MD 21122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments The following deficiencies are the result of an unannounced monitoring visit conducted at Peartree at Shadow Oak on 09/26/13, for the purpose of determining the facility ' s compliance with COMAR 10.07.14, Assisted Living Program Regulations. Survey activities included an environmental tour, interview of staff and residents, review of administrative records, five (5) resident records and five (5) staff records. The census at the time of the survey was thirteen (13) residents.	E 000		
E2600	.19 B6,7 .19 Other Staff--Qualifications (6) Receive initial and annual training in: (a) Fire and life safety, including the use of fire extinguishers; (b) Infection control, including standard precautions, contact precautions, and hand hygiene; (c) Basic food safety; (d) Emergency disaster plans; and (e) Basic first aid by a certified first aid instructor; (7) Have training or experience in: (a) The health and psychosocial needs of the population being served as appropriate to their job responsibilities; (b) The resident assessment process; (c) The use of service plans; and (d) Resident's rights; and This REQUIREMENT is not met as evidenced by: 10.07.14.19 B. 6 (a-e) Based on staff record review and staff interview, the facility failed to provide documentation of all initial and annual training as required by Regulation .19B (6) of this chapter.	E2600		

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0224	A. BUILDING: _____ B. WING _____	R 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARTREE HOUSE	8004 SHADOW OAK LANE PASADENA, MD 21122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E2600	Continued From page 1 Findings include: Staff member #4 was hired on 9/9/13 and Staff member #5 was hired on 9/10/13. Review of Staff members #4 and #5 ' s records revealed the initial training in basic first aid has not yet been completed.	E2600		
E2630	.19 C .19 Other Staff--Qualifications C. With the exception of certified nursing assistants (CNAs) and geriatric nursing assistants (GNAs), if job duties involve the provision of personal care services as described in Regulation .28D of this chapter, an employee: (1) Shall demonstrate competence to the delegating nurse before performing these services; and (2) May work for 7 days before demonstrating to the delegating nurse that they have the competency to provide these services, if the employee is performing tasks accompanied by: (a) A certified nursing assistant; (b) A geriatric nursing assistant; or (c) An individual who has been approved by the delegating nurse. This REQUIREMENT is not met as evidenced by: 10.07.14.19.C (2) Based on staff record review, staff failed to demonstrate competence in performing personal care services to the delegating nurse. Findings include: Staff member # 4 was hired on 9/9/13. Staff member #5 was hired on 9/10/13. Review of Staff members # 4 and #5 ' s records failed to provide documentation that Staff members #4 and #5	E2630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0224	A. BUILDING: _____ B. WING _____	R 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARTREE HOUSE	8004 SHADOW OAK LANE PASADENA, MD 21122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E2630	Continued From page 2 demonstrated competence in performing personal care services to the delegating nurse.	E2630		
E2730	.19 G4 .19 Other Staff--Qualifications (4) Ongoing training in cognitive impairment and mental illness shall be provided annually consisting of, at a minimum: (a) 2 hours for employees whose job duties involve the provision of personal care services as described in Regulation .28D of this chapter; and (b) 1 hour for employees whose job duties do not involve the provision of personal care services as described in Regulation .28D of this chapter. This REQUIREMENT is not met as evidenced by: 10.07.14.19. G.4 (a) Based on staff record review, staff failed to provide documentation of 2 hours of ongoing training in cognitive impairment and mental illness annually for employees whose job duties involve the provision of personal care services. Findings include: Staff member #3 provides personal care services to residents. Review Staff member #3 ' s record failed to provide current documentation of 2 hours of ongoing training in cognitive impairment and mental illness annually for employees whose job duties involve the provision of personal care services.	E2730		
E3330	.26 B1,2 .26 Service Plan B. Assessment of Condition. (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident	E3330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0224	A. BUILDING: _____ B. WING _____	R 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARTREE HOUSE	8004 SHADOW OAK LANE PASADENA, MD 21122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E3330	Continued From page 3 Assessment Tool. (2) A full assessment of the resident shall be completed: (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and (ii) Each nonroutine hospitalization; and (b) At least annually. This REQUIREMENT is not met as evidenced by: 10.07.14.26. B.2. (a-b) Based on resident record review, the facility failed to provide documentation of a completed full assessment on a resident within 48 hours but not later than required by nursing practice and the resident ' s condition after a significant change in condition, and each nonroutine hospitalization and at least annually. Findings include: Review of Resident #3 ' s record revealed the most current full assessment of Resident #3 was completed on 5/24/12.	E3330		
E3380	.26 C3 .26 Service Plan (3) The service plan is reviewed by staff at least every 6 months, and updated, if needed, unless a resident's condition or preferences significantly change, in which case the assisted living manager or designee shall review and update the service plan sooner to respond to these changes. This REQUIREMENT is not met as evidenced by: 10.07.14.26 C (3) Based on resident record review, the ALM or designee, failed to review and update service	E3380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0224	A. BUILDING: _____ B. WING _____	R 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARTREE HOUSE	8004 SHADOW OAK LANE PASADENA, MD 21122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E3380	Continued From page 4 plans at least every 6 months, or sooner, if a resident ' s conditions or preferences significantly change. Findings include: Review of Resident #1 ' s record revealed the service plan was written on 6/15/13. The service plan fails to include Resident #1 ' s chest pain treated with nitroglycerin and how Resident #1 ' s social and spiritual needs will be met. Review of Resident #2 ' s record revealed that the service plan for Resident #2 has not been updated since 2/28/13. Review of Residents # 3 ' s record revealed that the service plan for Resident #3 has not been updated since 9/26/12. Review of Resident #5 ' s service plan failed to reveal need for mouth checks due to Resident #5 removing medications from her mouth and her disrespectful behavior to staff and how the staff members should respond.	E3380		
E3680	.29 M .29 Medication Management and Administration M. Medications and treatments shall be administered consistent with current signed medical orders and using professional standards of practice. This REQUIREMENT is not met as evidenced by: 10.07.14.29.M Based on record review, medications and treatments failed to be administered consistent with current signed medical orders and using professional standards of practice.	E3680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0224	A. BUILDING: _____ B. WING _____	R 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARTREE HOUSE	8004 SHADOW OAK LANE PASADENA, MD 21122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E3680	Continued From page 5 Findings include: Resident #3 has a medical order for lisinopril 10 mgs. take 1 tablet by mouth twice daily for hypertension and another order for Toprol ER 50 mgs.-take 1 tablet twice daily for hypertension. Resident #3 also has an order to check blood pressure and pulse daily before administering blood pressure medications; call RN if blood pressure <100/70 or pulse <60. Review of the medication administration record for Resident #3 for the month of September revealed that Resident #3 ' s pulse was documented as < 60 ten times in the morning and nineteen times in the evening. Documentation could not be found that the RN had been called each of these times and both blood pressure medications were administered each of these times.	E3680		